STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155786	A. BUILDING _____ B. WING _____	C 02/27/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLISONVILLE MEADOWS	**10312 ALLISONVILLE RD FISHERS, IN 46038**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS This visit was for the Investigation of Complaint IN00123886. This visit was in conjunction with a Post Survey Revisit (PSR) to the Investigation of Complaint IN00122021 completed on 1/14/13. Complaint IN00123886 - Substantiated. No deficiencies related to the allegations are cited. Survey dates: February 25 & 26, 2013 Facility number: 012466 Provider number: 155786 AIM number: 201014060 Survey team: Christi Davidson, RN Census bed type: SNF: 35 SNF/NF: 118 Total: 153 Census payor type: Medicare: 35 Medicaid: 106 Other: 12 Total: 153 Sample: 3 Allisonville Meadows was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2, in regard to the Investigation of Complaint IN00123886.	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 000	Continued From page 1 Quality Review completed by Tammy Alley RN on March 1, 2013.	F 000		